Understanding the Impact of Health IT in Underserved Communities and Those with Health Disparities

HIMSS Latino Initiative

March 24, 2011
Agenda

- Project mandate/overview
- Staff/Expert panel
- Research Design
  - Research Questions & Methods
  - Case Study Selection Criteria
  - Discussion of Potential Cases
  - Analysis Approach
- Timeline & Next Steps
American Recovery & Reinvestment Act Legislative Mandate

• Section 13101, Subtitle A, Sec. 3001 (c)(6)(C) Assessment of Impact of HIT on Communities with Health Disparities and Uninsured, Underinsured, and Medically Underserved Areas.

  “The National Coordinator shall assess and publish the impact of health information technology in communities with health disparities and in areas with a high proportion of individuals who are uninsured, underinsured, and medically underserved individuals (including urban and rural areas) and identify practices to increase the adoption of such technology by health care providers in such communities, and the use of health information technology to reduce and better manage chronic diseases.”
Project Overview

• Examine the impact of HIT on care delivered to populations facing disparities, as well as those deemed medically underserved

• Generate key recommendations as to how HIT can be adopted and used more systematically among vulnerable communities
Expert Panel

• Ignatius Bau, JD, Health Policy Consultant, California Pan Ethnic Health Foundation
• Helen Burstin, MD, MPH, Senior Vice President, Performance Measures, National Quality Forum
• Neil Calman, MD, ABFP, FAAFP, President and Chief Executive Officer, Institute of Family Health
• Sarah Chouinard, MD, Medical Director, Community Health Network of West Virginia
• Theresa Cullen, MD, CIO and Director of the Office of IT, Indian Health Service
• Stephanie Ferguson, PhD, RN, FAAN, Associate Professor and Coordinator, Virginia Commonwealth University, School of Nursing, Community Nursing Organization
• Jessica Briefer French, MHSA, Senior Consultant for Research & Analysis, National Committee on Quality Assurance
• Garth Graham, MD, MPH, Deputy Assistant Secretary for Minority Health, Office of Minority Health
• R. Scott Hawkins, MBA, Chief Information Officer, Boston Healthcare for the Homeless Program
Expert Panel, Cont.

- **David Hunt, MD, FACS**, Chief Medical Officer, Office of the National Coordinator for Health IT
- **Jessica Kahn, MPH**, Technical Director for Health IT, Center for Medicaid and State Operations, CMS
- **Kathy Lim Ko, MS**, President & CEO, Asian and Pacific Islander American Health Forum
- **Leighton Ku, PhD, MPH**, Professor, School of Public Health and Health Services, George Washington University
- **Michael Lardiere, LCSW**, Clinical Affairs Director, Health Information Technology, National Association of Community Health Centers
- **Jennifer Lundblad, PhD, MBA**, President & CEO, Stratis Health
- **Ruth Perot, MAT**, Managing Director, National Health IT Collaborative for the Underserved
- **Elena Rios, MD, MSPH**, President & CEO, National Hispanic Medical Association
- **Byron Sogie-Thomas, MS**, Director, Office of Health Policy and Government Relations, National Medical Association
- **Cynthia Solomon, EdD**, President, Follow Me
Government

HRSA

• Yael Harris, Director, Office of Health Information Technology & Quality
• Miryam Gerdine, Office of Health Information Technology & Quality
• Mike McNeely, Office of Rural Health Policy
• Nidhi Singh, Office of Planning, Analysis and Evaluation

ONC

• Matt Swain
• Tom Tsang

AHRQ

• Samuel Zuvekas, Center for Financing, Access, and Cost Trends
NORC

• Adil Moiduddin, Associate Director of Health Care Research
• Cheryl Austein Casnoff, Senior Fellow, Public Health Department
• Prashila Dullabh, Program Area Director, Health Care Department
• Jessica Bushar, Senior Research Analyst, Public Health Department
• Ashley Nathanson, Research Analyst, Health Care Department
• Elizabeth Babalola, Research Analyst, Health Care Department

Consultant

• M. Chris Gibbons, Associate Director, Johns Hopkins Urban Health Institute
Methods

- Literature review and environmental scan
  - Develop parameters for key inclusion and exclusion criteria for the study
- Conduct 9 case studies
  - Potential case study components:
    - In-person key informant discussions
      - Target respondents may include: clinicians, IT staff, FQHC administrators, hospital staff, consumer advocates & IT vendors
    - Focus group discussions with community members
      - Target respondents include provider staff or consumers that are users or non-users of HIT
    - User observation study
      - Target respondents include provider staff or consumers that regularly interact with HIT
Key Research Questions

• To what extent can health IT help reduce or eliminate health-care disparities and/or improve access for the medically underserved?

• Are there specific types of health IT that are especially well-suited to address the clinical and personal needs (e.g., chronic disease management) of those subject to disparities and the medically underserved?

• What are the unique barriers to health IT adoption—financial, structural, cultural, etc.—among these vulnerable populations?
• Are there particular barriers to health IT adoption among providers who serve underserved populations? Are there particular barriers to patients who are medically underserved?

• What practices have been used to increase the adoption of health IT by providers serving these communities? How has health IT been used to reduce and better manage chronic diseases?

• Are there any unanticipated consequences of health IT that might contribute to disparities in health care or quality?
Framing the Project: “Medically Underserved”

• No single, universal definition:
  • Has been defined by NIH & HRSA (medically underserved areas & medically underserved populations)

• Common elements used to categorize the “medically underserved” population:
  • Poor
  • Uninsured
  • Limited English language proficiency
  • Lack of familiarity with the health care delivery system
  • Live in locations where providers are not readily available to meet their needs
Framing the Project: “Health Disparity”

• Approximately 11 different definitions, including:
  • IOM (2002 Unequal Treatment Report), AHRQ (National Healthcare Disparities Report), NIH, National Center for Minority Health and Health Disparities (Minority Health and Health Disparities Research and Education Act), among others

• Difference in one or more of the following elements:
  • Access to care
  • Utilization of care
  • Quality of care
  • Health status
  • Health outcomes

• Priority populations where disparities may exist:
  • Racial and ethnic minorities
  • Immigrant/limited-English populations
  • Poor
  • Women
  • Disabled/ special health care needs
  • Older adults
  • Rural residents
  • GLBTQ
  • Children
Framing the Project: “Health Information Technology (HIT)”

• “Hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for or support the use by health care entities or patients for the electronic creation, maintenance, access, or exchange of health information” –HITECH Act
  • May also include other technologies, such as social networking sites, kiosks, smart phone applications, etc.
Case Study Approach

- Eligibility criteria for potential case studies limited site selection to the following:
  - Communities where stakeholders have actively employed health IT in settings that are specific to the underserved
  - Communities where health IT interventions have targeted elimination of disparities as a primary goal
  - Specific community-level interventions that use health IT to address disparities or meet the needs of underserved populations
Case Study Approach Continued

• We will engage a range of potential stakeholders as part of the case studies:
  • Providers, case workers, patients, public health officials, community leaders, patient advocates, vendors and developers, health IT professionals
• Stakeholders will be engaged through interviews, focus groups or user observations, depending on the site
Case Study Selection

- Potential case studies were identified based on a review of the literature and suggestions from technical expert panelists.
- For each potential case study identified, NORC staff collected available information on the site through online searches and follow-up with technical expert panelists and others who recommended case studies.
- Available information collected on potential case studies was then organized into a potential case study matrix, which organized available information by specific selection factors. Selection factors used in this process are included on the next slide.
## Discussion of Research Design

### Case Study Selection Criteria

<table>
<thead>
<tr>
<th>Selection Factors</th>
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<tbody>
<tr>
<td>Location (Urban/Rural)</td>
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<tr>
<td>Specific Disparity/Population Targeted (Including Limited English Proficiency)</td>
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<tr>
<td>Provider/Caregiver Setting</td>
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<tr>
<td>Health Focus Area (Chronic Disease?)</td>
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<tr>
<td>Outcome Data Available?</td>
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<tr>
<td>Duration of Project</td>
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<tr>
<td>Targets Patients versus Providers</td>
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<tr>
<td>Intervention versus non-Intervention?</td>
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<tr>
<td>Type of health IT</td>
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<tr>
<td>Previously studied?</td>
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<td>Disparities related goal?</td>
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Discussion of Research Design

Case Study Selection Criteria Continued

- Using available information on selection factors, potential case studies were prioritized using a two-tier system:
  - **Tier 1** met the following conditions and were therefore identified as priority projects:
    - (1) Target specific populations with disparities
    - (2) Set specific goals related to addressing disparities
    - (3) Have outcomes data available
    - (4) Have not been studied extensively previously
  - **Tier 2** did not meet all of these criteria.
- No potential case studies fall into the Tier 1 category. Tier 2 will be chosen for further study using the Tier 1 conditions while ensuring there is sufficient variety in the factors identified on the previous slide (Type of HIT, etc.).
Program Characteristics

- EHR/Clinical Decision Support
- PHRs/Patient Engagement
- Provider Coordination
- Cross-Sector Coordination
- Case Workers, Outreach
- Population Specific Strategies
- Technology Platform
Timeline

• January 2011: Expert Panel Teleconference Call
• February 2011: Study Framework Revision and Finalization of Briefing Paper
• March 2011: Study Framework Execution
• July 2011: Draft Report
• September 2011: Expert Panel In-person Meeting
• September 2011: Briefing Report
Next Steps

• September 2011 in-person meeting (2011)
  • Washington, DC Metropolitan Area
  • Provide update on case studies
  • Seek feedback on the Draft Briefing Report
Next Steps

Additional Questions?

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